



APPLICATION FOR ADMISSIONS

Please print clearly and complete this form in full.

PERSONAL INFORMATION

Name: First Last Middle

Birth date: (DD/MM/YY)

Sex: Male Female Other Gender Identity (optional)

Street Name:

City: Province: Postal Code:

Telephone (Home) (Work) (Cell)

E-mail:

Alternative Contact Information

Name: Relationship: Tel:

Contact Person In Case of Emergency

Name: Relationship: Tel:

WHICH PROGRAM ARE YOU APPLYING FOR: Local Anesthetics for Dental Hygienists

WHICH START DATE ARE YOU APPLYING FOR: ?

Month & Year

EDUCATION:

Where did you complete your Dental Hygiene education?

Name of School:

Location of School:

Date of Graduation:

LICENSE/REGISTRATION:

Where are you currently licensed/registered to practice dental hygiene?



Vancouver CollegeTM of Dental Hygiene^{INC.}

Province/State:

Are you currently working as a dental hygienist? Yes No

You will be required to practice in the 3 weeks between the first and second course weekends under the supervision of a licensed dentist.

Name of dentist you will be practicing with:

SIGNATURE

I certify that all of the above information is correct and complete.

I will provide all required documents to the admissions office.

I have read over the entrance requirements and qualify to take this course.

Print Name:

Signature:

Date:

Scan the application to: info@vancouver-college-dental.org

Fax application to: 604-215-7660

Mail application to:

Vancouver College of Dental Hygiene Inc.

1205 – 6th Ave., New Westminster B.C.

V3M 2C1

Attention: Admissions Department